STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345213	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lillington Health and Rehabilitation Center	1995 East Cornelius Harnett Boulevard Lillington, NC 27546

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, resident, family, and home health agency staff members, the facility failed to have an effective discharge planning process that ensured a referral with all required documentation was submitted to the home health agency Resident # 5 selected resulting in a delay of planned services when the resident was discharged . This was for one (Resident # 5) of one resident reviewed for discharge services.The findings included:Resident # 5's hospital Discharge summary, dated [DATE], revealed Resident # 5 had undergone a total left hip replacement surgery.Resident #5 was admitted to the facility on [DATE]. Resident # 5's care plan, dated 7/28/25, noted Resident # 5 was expected to be at the facility for short term rehabilitation and return to the community setting. An intervention on the care plan noted upon discharge the resident was to be referred to community resources as indicated and per the resident or the resident's representative's preference.On 7/28/25 at 3:32 PM the Social Worker documented a discharge planning note which indicated the following information. The resident's family was involved in his care, and the resident planned to return home where he resided alone.Resident # 5's admission Minimum Data Set assessment, dated 7/31/25, revealed the resident was cognitively intact.On 8/5/25 (Tuesday) at 5:06 PM the Social Worker documented the following information. Resident # 5 was discharging home alone on 8/7/25 (Thursday). The family was aware and all equipment had been ordered. Home Health Agency # 2 was scheduled to begin services on 8/8/25 (Friday).On 8/7/25 (Thursday) at 5:02 PM the Social Worker documented the following information. The family had called and requested for the home health agency to be changed. They spoke to Home Health Agency # 1 and they would start care on 8/12/25 (which corresponded to the Tuesday following the resident's discharge the previous Thursday).According to the record, Resident # 5 was discharged home on 8/7/25 per order with home health services to be provided.Resident # 5's family member was interviewed on 8/7/25 at 3:53 PM and reported the following information. Other family members had utilized Home Health Agency # 1 in previous times and had been pleased. Therefore, Resident # 5 had wanted his home health services also provided by Home Health Agency # 1 when he was discharged . She (the family member) was helping Resident # 5 by making sure things were in place for him to go home. She (the family member) had spoken to the Social Worker on 8/4/25 (Monday) and requested that the home health referral be made to Home Health Agency # 1, and she thought this was to be set up for Resident # 5. On 8/6/25 she had left a message on the voice mail for the Social Worker to make sure everything was arranged and did not hear anything back. On the day of discharge, she learned that the referral had been sent to Home Health Agency # 2. She talked to the Social Worker who said they did not hear back from Home Health Agency # 1. She in turn called Home Health Agency # 1 and found they had not received any orders from the facility but were willing to accept him (Resident # 5) and provide services. She again let the facility know Resident # 5 wanted Home Health Agency # 1 and orders were sent to them on the day of discharge. The resident was safe and at home on the day of discharge but because the referral had not been sent in timely, Resident # 5 was having to wait on services until 8/12/25. The family member thought there should have been better communication.Resident # 5 was interviewed on 8/8/25 at 10:20 AM and reported the following information. He and his family member had talked to the Social Worker and conveyed that he wanted Home Health Agency # 1 to provide services when he went home. That had not been initially arranged and now he was having to wait until 8/12/25 for services to begin. In the interim, he was safe and had family to help until home health began.On 8/11/25 at 9:30 AM the Social Worker was interviewed and reported the following information. On 8/4/25 Resident # 5's family member did let her know that the resident preferred Home Health Agency # 1. She emailed the agency to see if they would accept the referral and did not hear back. She waited a few hours, emailed again, and did not hear back. She then made the referral to Home Health Agency # 2. She did not recall telling the resident or family about the change and she did not try to call Home Health Agency # 1 before switching the referral to another home health agency.A Scheduler at Home Health Agency # 1 was interviewed on 8/11/25 at 10:40 AM and reported the following information. They had a Healthcare Liaison who could take referrals, or the facility could call their general intake line and the information could be given to them. As the Scheduler she did not get any information related to Resident # 5 until 8/7/25 (the day of Resident # 5's discharge) and they let the facility know they could not be out until 8/12/25. Services were scheduled to begin on 8/12/25. The Scheduler was interviewed regarding if they could have started services by 8/8/25 (the day following discharge) if the facility had sent the referral

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident and staff the facility failed to ensure an accurate accounting and administration of a controlled pain medication. This was for one (Resident # 5) of three residents whose controlled pain medication records were reviewed. The findings include:Record review revealed Resident # 5 was admitted to the facility on [DATE] after being hospitalized for hip replacement surgery.Review of Resident # 5's admission Minimum Data Set assessment, dated 7/31/25, revealed the resident was cognitively intact.Review of physician orders revealed an order, dated 7/30/25, for Tramadol 50 mg (milligrams) two times a day for pain for 14 days. (Tramadol is a controlled pain medication and must be signed out of storage when removed with a notation of when the medication was removed and by whom.)Review of Resident # 5's August MAR (Medication Administration Record) revealed the resident's Tramadol was scheduled for 8:00 AM and 8:00 PM. According to the MAR Nurse # 1 placed a check mark by Resident # 5's 8:00 PM dose on 8/5/25 and the electronic MAR showed Nurse # 1 signed in the electronic record she did so at 9:49 PM. Review of Resident # 5's Controlled Drug receipt/ Record/ Disposition Form revealed Nurse # 5 had written she removed Tramadol on 8/5/25 at 9:00 PM and then she placed a line through the entry noting mistake. According to this Controlled Drug receipt/Record/ Disposition Form there was no Tramadol removed on 8/5/25 from Resident # 5's supply.Resident # 5 was interviewed on 8/8/25 at 10:20 AM and reported on the evening of 8/5/25 he needed his pain medication, and it was very late before it was administered. Resident # 5 reported he received the pain medication around 11:00 PM on 8/5/25.Nurse # 5 was interviewed on 8/8/25 at 11:56 AM and reported that she had administered Resident # 5's Tramadol on 8/5/25 around 8:30 PM or 9:00 PM. Nurse # 1 was further interviewed regarding where she had obtained the Tramadol given that there had been no Tramadol signed out from Resident # 5's supply. Nurse # 1 reported the following information. She had inadvertently removed the Tramadol from Resident #6's supply. Resident # 6 was also on Tramadol and received it on an as needed basis. She discovered the error around 7:00 AM on 8/6/25 at the end of her night-time shift. At that point she signed on Resident # 6's Controlled Drug receipt/ Record/ Disposition Form that she had removed a Tramadol dose from Resident # 6's supply but did not note she had signed it out for another resident. Nurse # 1 further reported when she administered the pain medication around 8:00 PM or 9:00 PM, Resident # 5 had not indicated he had needed anything for pain earlier than his scheduled dose.A review of Resident # 6's Tramadol Controlled Drug receipt/ Record/ Disposition Form revealed the form included Resident # 6's order at the top of the form. The order was for Tramadol 50 mg every eight hours as needed. Doses were signed out on 8/5/25 at 6:01 PM and again at 10:00 PM which indicated a span of 3 hours and 59 minutes between doses. There was no notation that this was an error or that the 10:00 PM dose was signed out for another resident.During the interview with Nurse # 1 on 8/8/25 at 11:56 AM, Nurse # 1 was interviewed regarding why she did not put 8:30 PM or 9:00 PM as the time on Resident # 6's Tramadol Controlled Drug receipt/ Record/ Disposition Form since this was the time she was reporting she had inadvertently made the mistake. Nurse # 1 reported the time between 6:01 PM (Resident # 6's last removed dose) and 8:30 PM would have been close in time so she put 10:00 PM instead.The DON (Director of Nursing) was interviewed on 8/8/25 at 12:20 PM and reported the following information. When an inadvertent mistake is made in controlled pain medications, then the nurse should call a supervisor and there should be two signatures noted on the Controlled Drug receipt/ Record/ Disposition Forms what had occurred so that the records were clear and accurate.The facility's Nurse Consultant was interviewed on 8/8/25 at 3:25 PM regarding the discrepancies regarding the differing times of administration being reported by Resident # 5 and Nurse # 1 when compared to the documentation on the MAR and the removal of the Tramadol from storage. According to the Nurse Consultant nurses should document the times controlled pain medications are administered and they should match the MAR and the Controlled Drug receipt/ Record/ Disposition Forms.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews with staff, an employee at the local public health department and a commercial equipment service provider, the facility failed to ensure their kitchen dishwashing machine had the cleaning and sanitation chemical agents connected correctly into the dishwashing machine and also failed to ensure water leaks from the dishwashing machine were repaired to prevent water leaking multiple feet throughout the kitchen floor on multiple days. During the time the dishwasher was not functioning correctly, the facility continued to use the machine to wash reusable meal trays. This was for one of one dishwashing machines utilized by the facility to provide clean dishes for all halls of the facility.The findings included:On 8/5/25 at 12:45 PM an initial observation of the kitchen was made. At that time there was water on the floor spanning approximately 15 feet from the dishwasher. The Certified Dietary Manager (CDM) was interviewed at this time and reported the following information. They were currently using the dishwasher only to wash reusable trays (used to hold the disposable plates and utensils they were currently using to serve residents' meals). The facility had experienced problems with the dishwasher for several weeks. The dishwasher had two motors that lifted a mechanism to drain the contents of the dishwasher after each cycle. One of the motors was broken and on order. Therefore, when the dishwasher emptied, water would overflow onto the floor from the drain that did not work, and the staff would have to mop up the water.During a second observation of the kitchen on 8/6/25 at 10:40 AM the floor was observed to be wet again from the dishwasher. The wet area spanned approximately 15 feet away from the dishwasher. The CDM, who began facility employment on 6/23/25, was interviewed again and reported the following information. Since being employed at the facility, he thought the dishwasher was under a rental agreement, which he also thought entailed the rental company performing monthly service and maintenance checks. Since he had begun, the dishwasher had leaked numerous places. There were two areas at the top that had been squirting water towards the walls. A [NAME] eventually came and welded the holes. Part of the feed line had also separated from the dishwasher and was leaking. Therefore, it had been hard to tell how long the current problem with the motor being broken and causing water leakage had been occurring because there had been so many problems with the machine leaking. He (the CDM) thought at the current time it was only leaking during the rinse cycle because he noticed the problem when the machine showed it was going into the rinse cycle, and therefore he thought the water on the floor was only rinse water. The CDM further reported the following. The local health department had performed an inspection on 7/1/25 and reported that the machine was not sanitizing and the facility was instructed to use single service items for food service to residents. Since 7/1/25 he had used single service items except for reusable trays because of the malfunctioning dish washer. The local health department had instructed them to use the three compartment sink for sanitation if needed. They had tried using the three compartment sink for the reusable trays but found that the trays did not air dry quickly enough to be available for the next meal delivery time. He was not able to order single service trays because he worked for a contracting company which required him to get supplies from a specific supply company. That supply company did not have single service trays. Therefore, since it had been identified by the local health department that the dishwashing machine was not sanitizing, he would manually open the machine and insert the sanitizer. When the machine leaked then the kitchen staff would mop the floor. According to the CDM, a service provider came in on 7/18/25 and identified that the lines from the soap, rinse, and sanitizing agents were not correctly fed into the machine which had led to the machine not sanitizing the trays. The chemical agents usually lasted for about 1 1/2 to 2 weeks before they needed to be changed. He did not know when the chemical agents had last been changed prior to the error of the crossed lines being detected on 7/18/25. Therefore, he could not say how many days the trays had been going through the machine and out to residents without being sanitized. He did know that there had been multiple days of problems with the machine leaking water.A local Health Department Employee was interviewed on 8/6/25 at 9:23 AM and reported the following information. An inspection occurred on 7/1/25 by a colleague from the health department. The facility's dishwashing machine was not sanitizing on 7/1/25 at that visit. At that time the facility was directed to not use the dishwasher, use single service items for food service, and the three-compartment sink was to be used if needed for sanitation. She returned on 7/17/25 and the dishwasher was still broken and not sanitizing when checked. There was no evidence that the facility was using disposable meal service items at that time. There was also water on the floor. The CDM had reported to her

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews with staff, an employee at the local public health department and a commercial equipment service provider, the facility failed to ensure a mechanical dishwashing machine was operating correctly to prevent water leaking multiple feet throughout the kitchen floor on multiple days. This was for one of one dishwashing machines utilized by the facility to service dishes and trays for the entire facility. The findings included:On 8/5/25 at 12:45 PM an initial observation of the kitchen was made. At that time there was water on the floor spanning approximately 15 feet from the dishwasher. The Certified Dietary Manager (CDM) was interviewed at this time and reported the following information. They were currently using the dishwasher only to wash reusable trays (used to hold the disposable plates and utensils they were currently using to serve residents' meals). The facility had experienced mechanical problems with the dishwasher for several weeks. The dishwasher had two motors that lifted a mechanism to drain the contents of the dishwasher after each cycle. One of the motors was broken and on order. Therefore, when the dishwasher emptied, water would overflow onto the floor from the drain that did not work, and the staff would have to mop up the water.During a second observation of the kitchen on 8/6/25 at 10:40 AM the floor was observed to be wet again from the dishwasher. The wet area spanned approximately 15 feet away from the dishwasher. The CDM, who began facility employment on 6/23/25, was interviewed again and reported the following information. Since being employed at the facility, he thought the dishwasher was under a rental agreement, which he also thought entailed the rental company performing monthly service and maintenance checks. Since he had begun, the dishwasher had leaked numerous places. There were two areas at the top that had been squirting water towards the walls. A [NAME] eventually came and welded the holes. Part of the feed line had also separated from the dishwasher and was leaking. Therefore, it had been hard to tell how long the current problem with the motor being broken and causing water leakage had been occurring because there had been so many problems with the machine leaking. He did know that there had been multiple days of problems with the machine leaking water.A local Health Department Employee was interviewed on 8/6/25 at 9:23 AM and reported the following information. An inspection occurred on 7/1/25 by a colleague from the health department. The facility's dishwashing machine was not sanitizing on 7/1/25 at that visit. At that time the facility was directed to not use the dishwasher, use single service items for food service, and the three-compartment sink was to be used if needed for sanitation. She returned on 7/17/25 and the dishwasher was still broken and not sanitizing when checked. There was also water on the floor. The CDM had reported to her that they were waiting for the health department's report to fix the dishwashing machine. She did not understand why the facility needed the report to fix the dishwashing machine. Since 7/17/25 the health department had received information from the facility that a service provider had found that the hoses were not tied into the cleaning agents correctly on 7/18/25 and that issue had been repaired but the facility had also submitted to the health department that the dishwashing machine needed further repairs.On 8/8/25 at 8:52 AM the commercial service provider, who was at the facility on 7/18/25, was interviewed and reported the following information. The facility owned the machine, and it was not rented. They (the service provider) did not do any routine service for machines that were not under contract with them. Also, their company did not do repairs for the facility. Their role was to supply the chemical agents for the machine. When he arrived on 7/18/25 he checked the chemical agents. He also observed while there that the machine had water coming out of the backside also and the motor to the drain was making a loud chatter. The drain line making the chatter seemed to be locking up and therefore it would not drain correctly. The Administrator and the CDM were interviewed together on 8/8/25 at 11:00 AM and reported the following. The Administrator reported it had not been conveyed to her that the dishwashing machine was not rented and rather was owned by the facility. That week (the week of the survey) she had learned at one time the machine had been rented and during a corporate buyout the previous year, the dishwashing machine had somehow become the property of the facility. When the health department employee arrived on 7/1/25 it was her understanding that they would give her a written report of the problem and provide some education. She thought education would be a good idea and they wanted to cooperate and were waiting on the actual report from the health department to have the machine fixed. In the interim, excluding the reusable trays, they were using disposable single use food service items to serve food to residents. The CDM was interviewed again about dates when the dishwashing machine had been leaking and repaired and reported that when he